Evaluation of the Care Manager Role in Primary Care

Malaika Stoll MD, MPA
Lehigh Valley Health Network

Lynn M. Deitrick RN, PhD
Lehigh Valley Health Network, Lynn.Deitrick@lvhn.org

Nancy Gratz MPA
Lehigh Valley Health Network, Nancy_C.Gratz@lvhn.org

Pam Marcks
Lehigh Valley Health Network, Pamela.Marcks@lvhn.org

Kathleen Moser
Lehigh Valley Health Network, Kathleen.Moser@lvhn.org

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Malaika Stoll MD, MPA ; Lynn Deitrick, PhD, RN; Nancy Gratz, MPA; Pam Marcks, Kathleen Moser • LEHIGH VALLEY HEALTH NETWORK ALLENTOWN, PENNSYLVANIA

BACKGROUND

What primary care cannot address in the office or clinic, it must coordinate. This is the essence of the medical home. Technological tools for supporting care coordination include Electronic Health Records, allowing information to flow across time and care-settings. Individuals can be identified to support care coordination, with various models for primary care "Care Managers" emerging.

Lehigh Valley Health Network (LVHN) is a large hospital and health network in Pennsylvania that operates in a multi-payer, largely fee-for-service environment. Seven LVHN primary care practices are participating in the PA Chronic Care Collaborative, a State-wide chronic care and patient Centered Medical Home (PCMH) pilot, funded by five commercial and one Medicaid payer. A requirement of the Pilot is identifying or hiring a Care Manager. There was flexibility in terms of the credentials of the care manager and the size of patient panel to be followed.

STUDY OBJECTIVE

- To describe the role of a Care Manager implemented as part of a PCMH Pilot, in a large, fee-for-service network.
- To identify important attributes of care managers, such as education/training level.
- To consider whether Care Managers in this context can contribute to the network goal of offering high value care to the community.

SETTING

- Implementation of a Care Manager position in six Lehigh Valley, PA primary care practices. Five are owned by LVHN and one is independent.
- All six practices were participants in the Pennsylvania State-sponsored Chronic Care Initiative/Patient Centered Medical Home pilot which mandated the Care Manager position.
- Participating practices are to be reimbursed for implementing a care manager. On average, each practice expects to receive about $30,000 per year for each of two years having a care manager in place. LVHN practices also received a $25,000 per practice (one time) grant from the Lehigh Valley Physician Hospital Association (LVPHO).
- Individual practices had autonomy in identifying Care Managers and in defining their role.

METHODS

Mixed methods design that includes qualitative and quantitative components. These are:

- Pre and post implementation interviews and focus groups with practice staff. Key areas include care management roles, responsibilities, qualifications, challenges and impact.
- Grounded theory method with thematic coding used to develop concepts from data systematically collected and analyzed.
- Pre/post hospital/ED utilization in patients in practices with care managers
- Pre/post risk assessment, using risk assessment tool we developed for diabetes

DISCUSSION

The mandate to provide high value care—care that is of the highest quality, at the lowest possible cost—is clear. Responding to this call is the PCMH, which promises to coordinate care, and thereby improve quality while reducing duplication, errors and unnecessary utilization. To assist with population management, care planning and care coordination, the PA Chronic Care Initiative/PCMH pilot requires that participating practices designate a Care Manager, and offers reimbursement when a Care Manager is successfully implemented.

In our study, the role of the Care Manager varies depending upon the background of the individual. As a network, we search for a more standardized approach, and continue to learn from the six "case studies" we are studying. Within the network, there has been animated debate over the ideal background of the care manager. From this study, we learn that there is a wide range of duties within, "care management," and individuals with a variety of backgrounds can fulfill parts of the job description. One strategy for resource-limited primary care practices may be to utilize a team approach to care management. That is, to take stock of the talents, interests and capacity of existing clinicians and staff, and divide up the key care management roles. Some parts of the job—such as patient reminders, coordinating referrals and so forth—do not require a highly clinical background. Other parts, such as reconciling complex medication lists, may require highly trained individuals such as CRNPs. Managing a registry likely requires some understanding of data and information systems. Many practices will not have this type of expertise readily available, and will require training.

The PCMH initiative resulted in all LVHN practices identifying individuals within the office to work part-time on care management activities. In all but one case, the Care Managers are devoting six or less hours per week to care management in practices that range in size from 1 to 8 physicians. Thus, only a very small percentage of patients can potentially benefit. Because of this, we are not surprised that ED visits, re-admissions and admissions have not yet changed substantially. Organizations that are motivated to implement full-time care managers are often "integrated" such that a reduction in utilization is actually a financial gain. Our findings that care managers became increasingly focused on the discharge process reflects the anticipated reduction in reimbursement for readmissions.

The primary care, care manager is relatively new within our network. We will continue to study the evolution of the care manager role using the methods presented. In addition, we are discussing more experimental approaches to studying the care manager position.

RESULTS

1. SNAPSHOT OF CARE MANAGERS

As seen in Table 1, all care managers are part time and there is wide variation in educational background.

Table 1: Practice Type and Credentials of Care Manager
(data obtained post-implementation, July/August 2010)

PRACTICE IDENTIFIER	PRACTICE TYPE	LEVEL OF CERTIFICATION	TIME SPENT AS CARE MANAGER
A	Network-Owned; Family Medicine	LPN	30 hrs week
B	Network-Owned, Family Medicine	CRNP	4–6 hrs per week
C	Network-Owned; Family Medicine	MSW/LPC	4 to 6 hours per week
D	Private; Family Medicine	MA	4–6+ hours per week
E	Network-Owned, Internal Medicine	CRNP	4 hrs week
F	Network-Owned, Internal Medicine	RN	6 hrs per week

2. CHANGING PERCEPTIONS OF THE CARE MANAGER

Table 2 demonstrates multiple themes emerging from pre and post implementation interviews with clinical practice staff.

- Across practices and across time, registry management and helping patients with self-management goals were identified as important responsibilities
- Initially, only one practice mentioned discharge reconciliation as an important care manager role; six months later, all practices considered it important
- Understanding of the varied tasks of the care management came with time, as did appreciation that individuals with a wide range of backgrounds can each fulfill parts of the job description. Post-implementation, three of the six practices indicated that care management should be a team—not an individual's—responsibility.

Table 2: Care Manager Perceptions: Pre and Post Implementation

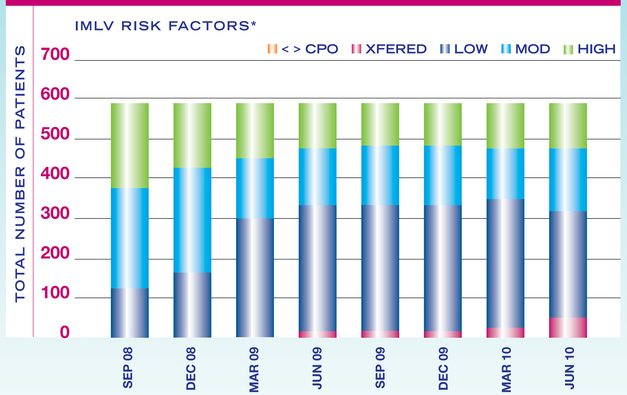
DESCRIPTION OF CARE MANAGER	PRE-CARE MANAGER RESPONSES BY PRACTICE	POST-CARE MANAGER RESPONSES BY PRACTICE	EXAMPLES OF COMMENTS
Integral part of a team approach to patient care	C, F	A, E, F	"Care management is not only doctor/patient care (which is not working) but care from a whole team with doctor, nurse, MA. A team approach is important, but implementation is difficult." "It's not one person's job. I take on the title CM, but it's not just me. It's all of us. All of us are the care manager."
Develop accurate registry and ID targeted chronically ill patients	A, B, C, E, F	A, B, C, D, F	"Our practice changed 'target' definition because if the CM worked with diabetic pts, there would be 550 pts. That's impossible for 1 P/T CM." "Registry changed in practices: from diabetes to high-risk population. With hospital discharges there are multiple diagnoses."
Patient engagement, self-management goals	All	A, B, C, F	"The CM is someone that picks up the phone and directly access the patient, knows their history" "It's more hand-holding than allowed time-wise in an office."
Coordinate patient discharge and follow-up	C	All	"Discharge reconciliation is the biggest responsibility and medication reconciliation is a big, big, big task." "Discharge reconciliation is all I have time to do"
Assist in achieving & maintaining medical home certification	none	All	"CM was "absolutely" a key role in medical home certification."
Care Manager can have varied education.	none	All	"Definition depends on office needs and what practices want CM to do—may not be standardized." *Oversee registry: does not require specific accreditation* *Extension of physician services/med reconciliation: RN, LPN* *Diabetic education: RN; Group visits: NP*

3. IMPROVING THE RISK PROFILE OF PATIENTS WITH DIABETES

The first graph below shows data for one typical practice. The decreasing red section, and the light gray area getting larger suggests diabetic patients moving from high to lower risk categories over time. A steady improvement over time is consistently noted across all the practices, and is seen in this practice. Note the risk assessment tool we used to assign points to patients, and thereby stratify them based on risk.

The second graph displays ED visits, admissions and re-admissions for patients with diabetes. The third graph shows this data for all patients in this practice. Data analysis will be conducted in the future; preliminary indications suggest that utilization has not substantially changed during the time period studied.

Table 3: Graph 1 Risk Stratification and utilization data for diabetic patients, quarterly data pre and post care manager implementation—sample from one "typical" practice



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